		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038760

Facility Name: FLORA PAVILION NURSING HOME CTR

Address: 701 SHADWELL (Number) FLORA (City) 62839 (Zip Code)

County: CLAY

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-1304216

Date of Initial License for Current Owners: 2/1/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) BRADLEY ALTER

(Title) VICE PRESIDENT

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W. DEVON LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	56	Skilled (SNF)	56	20,440	1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,710	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,445	3,445	8
9	SNF/PED					9
10	ICF	18,311	5,775	456	24,542	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,311	5,775	3,901	27,987	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.71%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 3,445

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	110,000	9,322	2,491	121,813		121,813	0	121,813			1
2	Food Purchase		129,142		129,142		129,142	(4,619)	124,523			2
3	Housekeeping	70,099	10,017	0	80,116		80,116	300	80,416			3
4	Laundry	31,533	8,108	0	39,641		39,641	0	39,641			4
5	Heat and Other Utilities			65,601	65,601		65,601	484	66,085			5
6	Maintenance	39,264	27,425	14,101	80,790		80,790	5,273	86,063			6
7	Other (specify):* scavenger			9,382	9,382		9,382	0	9,382			7
8	**TOTAL General Services**	250,896	184,014	91,575	526,485	0	526,485	1,438	527,923			8
	B. Health Care and Programs											
9	Medical Director	0		6,500	6,500		6,500	0	6,500			9
10	Nursing and Medical Records	822,878	91,744	7,979	922,601		922,601	12,872	935,473			10
10a	Therapy	39,476	4,928	3,059	47,463		47,463	(77,775)	(30,312)			10a
11	Activities	54,903		2,614	57,517		57,517	0	57,517			11
12	Social Services	21,191		0	21,191		21,191	0	21,191			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	938,448	96,672	20,152	1,055,272	0	1,055,272	(64,903)	990,369			16
	C. General Administration											
17	Administrative	48,094		17,750	65,844		65,844	15,894	81,738			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			41,276	41,276		41,276	7,370	48,646			19
20	Dues, Fees, Subscriptions & Promotions			31,190	31,190		31,190	(15,267)	15,923			20
21	Clerical & General Office Expenses	42,207	15,379	116,881	174,467		174,467	(20,808)	153,659			21
22	Employee Benefits & Payroll Taxes			221,147	221,147		221,147	21,337	242,484			22
23	Inservice Training & Education			0	0		0	0	0			23
24	Travel and Seminar			1,496	1,496		1,496	7,031	8,527			24
25	Other Admin. Staff Transportation			5,050	5,050		5,050	8,689	13,739			25
26	Insurance-Prop.Liab.Malpractice			52,078	52,078		52,078	3,357	55,435			26
27	Other (specify):*			0	0		0	0	0			27
28	**TOTAL General Administration**	90,301	15,379	486,868	592,548	0	592,548	27,603	620,151			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,279,645	296,065	598,595	2,174,305	0	2,174,305	(35,862)	2,138,443			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR #0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			29,667	29,667		29,667	121,085	150,752			30
31	Amortization of Pre-Op. & Org.				0		0	2,438	2,438			31
32	Interest			38,318	38,318		38,318	352,635	390,953			32
33	Real Estate Taxes			63,774	63,774		63,774	0	63,774			33
34	Rent-Facility & Grounds			464,682	464,682		464,682	(460,568)	4,114			34
35	Rent-Equipment & Vehicles			11,997	11,997		11,997	0	11,997			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			608,438	608,438	0	608,438	15,590	624,028			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers			79,663	79,663		79,663	75,882	155,545			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			60,225	60,225		60,225	0	60,225			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	0	139,888	139,888	0	139,888	75,882	215,770			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,279,645	296,065	1,346,921	2,922,631	0	2,922,631	55,610	2,978,241			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,467)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(4,076)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(543)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(375)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(15,021)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(555)	20		28
29	Other-Attach Schedule SEE PAGE 5A	4,776			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,261)		$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	100,871	SCHED	34
35	Other- Attach Schedule		ATTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 100,871		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 55,610		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FLORA PAVILION NURSING HOME CTR

ID# 0038760

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 4776	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	4,776		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,619)	0	0	0	0	0	0	0	0	0	0	(4,619)	2
3	Housekeeping	0	0	300	0	0	0	0	0	0	0	0	300	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	484	0	0	0	0	0	0	0	0	484	5
6	Maintenance	4,776	0	497	0	0	0	0	0	0	0	0	5,273	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	157	0	1,281	0	0	0	0	0	0	0	0	1,438	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	12,872	0	0	0	0	0	0	0	0	12,872	10
10a	Therapy	0	(77,775)	0	0	0	0	0	0	0	0	0	(77,775)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(77,775)	12,872	0	0	0	0	0	0	0	0	(64,903)	16
	C. General Administration													
17	Administrative	0	(17,750)	33,644	0	0	0	0	0	0	0	0	15,894	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	7,050	320	0	0	0	0	0	0	0	7,370	19
20	Fees, Subscriptions & Promotions	(15,576)	0	309	0	0	0	0	0	0	0	0	(15,267)	20
21	Clerical & General Office Expenses	(375)	(95,297)	72,224	2,640	0	0	0	0	0	0	0	(20,808)	21
22	Employee Benefits & Payroll Taxes	0	0	14,189	7,148	0	0	0	0	0	0	0	21,337	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,921	1,110	0	0	0	0	0	0	0	7,031	24
25	Other Admin. Staff Transportation	0	0	6,072	2,617	0	0	0	0	0	0	0	8,689	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,357	0	0	0	0	0	0	0	0	3,357	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(15,951)	(113,047)	142,766	13,835	0	0	0	0	0	0	0	27,603	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(15,794)	(190,822)	156,919	13,835	0	0	0	0	0	0	0	(35,862)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(29,467)	148,398	2,154	0	0	0	0	0	0	0	0	121,085	30
31	Amortization of Pre-Op. & Org.	0	2,438	0	0	0	0	0	0	0	0	0	2,438	31
32	Interest	0	352,580	55	0	0	0	0	0	0	0	0	352,635	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(464,702)	4,134	0	0	0	0	0	0	0	0	(460,568)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(29,467)	38,714	6,343	0	0	0	0	0	0	0	0	15,590	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	75,882	0	0	0	0	0	0	0	75,882	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	75,882	0	0	0	0	0	0	0	75,882	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(45,261)	(152,108)	163,262	89,717	0	0	0	0	0	0	0	55,610	45

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CERTIFIED HEALTI	SKOKIE	MANAGEMENT/
				MANAGEMENT		BOOKKEEPING
				CHM THERAPY	SKOKIE	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 17,750	CERTIFIED HEALTH MANAGEMENT		$	$ (17,750)	1
2	V	21	BOOKKEEPING FEES	99,960	CERTIFIED HEALTH MANAGEMENT			(99,960)	2
3	V								3
4	V								4
5	V	10a	THERAPY	77,775	CHM THERAPY			(77,775)	5
6	V								6
7	V	34	RENT	464,702	FLORA PAVILION NURSING HOME LLC			(464,702)	7
8	V								8
9	V	21	OFFICE EXPENSE		" " " "		4,663	4,663	9
10	V	30	DEPRECIATION		" " " "		148,398	148,398	10
11	V	31	AMORTIZATION		" " " "		2,438	2,438	11
12	V	32	INTEREST		" " " "		352,580	352,580	12
13	V								13
14	Total			$ 660,187			$ 508,079	$ * (152,108)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$			$ 300	$ 300	15
16	V	5	ELECTRICITY & GAS				484	484	16
17	V	6	MAINTENANCE				497	497	17
18	V	10	NURSING/MEDICAL RECORDS				12,872	12,872	18
19	V	17	ADMIN SALARIES				33,644	33,644	19
20	V	19	PROFESSIONAL FEES				7,050	7,050	20
21	V	20	FEES, SUBSCRIPTIONS				309	309	21
22	V	21	OFFICE EXPENSE				72,224	72,224	22
23	V	22	EMPLOYEE BENEFITS				14,189	14,189	23
24	V	24	TRAVEL/SEMINAR				5,921	5,921	24
25	V	25	TRANSPORTATION				6,072	6,072	25
26	V	26	INSURANCE				3,357	3,357	26
27	V	30	DEPRECIATION				2,154	2,154	27
28	V	32	INTEREST				55	55	28
29	V	34	OFFICE RENT				4,134	4,134	29
30	V	35	EQUIPMENT RENT				0		30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 163,262	$ * 163,262	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	THERAPY	$			$ 75,882	$ 75,882	15
16	V	19	PROFESSIONAL FEE				320	320	16
17	V	21	OFFICE EPXNESE				2,640	2,640	17
18	V	22	EMPLOYEE BENEFITS				7,148	7,148	18
19	V	24	TRAVEL/SEMINARS				1,110	1,110	19
20	V	25	TRANSPORTATION				2,617	2,617	20
21	V	35	EQUIPMENT RENT				0		21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 89,717	$ * 89,717	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTI # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRADLEY ALTER		ADMINISTRATIVE			SCHEDULE ATTACHED			$ 13,025	17-3	1
2	HOWARD GELLER		ADMINISTRATIVE						4,725	19-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 17,750		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	279,537	8	$ 3,000	$	27,987	$ 300	1
2	5	ELECTRICITY & GAS	" " "	279,537	8	4,839		27,987	484	2
3	6	MAINTENANCE	" " "	279,537	8	4,965		27,987	497	3
4	10	NURSING/MEDICAL RECORD	" " "	279,537	8	128,566	128,566	27,987	12,872	4
5	17	ADMIN SALARIES	" " "	279,537	8	336,038	336,038	27,987	33,644	5
6	19	PROFESSIONAL FEES	" " "	279,537	8	70,412		27,987	7,050	6
7	20	FEES, SUBSCRIPTIONS	" " "	279,537	8	3,089		27,987	309	7
8	21	OFFICE EXPENSE	" " "	279,537	8	721,384	572,980	27,987	72,224	8
9	22	EMPLOYEE BENEFITS	" " "	279,537	8	141,722		27,987	14,189	9
10	24	TRAVEL/SEMINAR	" " "	279,537	8	59,144		27,987	5,921	10
11	25	TRANSPORTATION	" " "	279,537	8	60,651		27,987	6,072	11
12	26	INSURANCE	" " "	279,537	8	33,528		27,987	3,357	12
13	30	DEPRECIATION	" " "	279,537	8	21,518		27,987	2,154	13
14	32	INTEREST	" " "	279,537	8	549		27,987	55	14
15	34	OFFICE RENT	" " "	279,537	8	41,293		27,987	4,134	15
16	35	EQUIPMENT RENT	" " "	279,537	8				0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,630,698	$ 1,037,584		$ 163,262	25

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CHM THERAPY
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	THERAPY	USAGE	100	5	$ 271,007	$ 271,007	28	$ 75,882	1
2	19	PROFESSIONAL FEE	USAGE	100	5	1,143		28	320	2
3	21	OFFICE EPXNESE	USAGE	100	5	9,430		28	2,640	3
4	22	EMPLOYEE BENEFITS	USAGE	100	5	25,530		28	7,148	4
5	24	TRAVEL/SEMINARS	USAGE	100	5	3,963		28	1,110	5
6	25	TRANSPORTATION	USAGE	100	5	9,348		28	2,617	6
7	35	EQUIPMENT RENT	USAGE	100	5				0	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 320,421	$ 271,007		$ 89,717	25

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	BANK FINANCIAL		X	MORTGAGE	$8,399.00	4/00	$ 405,904	$ 314,092	9/02	10.5000	$ 27,247	1
2	GERSHON BASSMAN	X		MORTGAGE	$9,635.00	4/00	1,014,760	983,063	3/20	9.7500	96,776	2
3	CIB BANK		X	MORTGAGE	$22,639.00	4/000	2,354,244	2,290,665	3/20	9.7500	228,557	3
4												4
5												5
	Working Capital											
6	CIB BANK		X	WORKING CAPITAL				329,994		PRIME+	30,745	6
7	SHAREHOLDER/OFFICER	X		WORKING CAPITAL				479,969			6,403	7
8	RELATED PARTY/INS FIN	X									1,225	8
9	TOTAL Facility Related				$40,673.00		$ 3,774,908	$ 4,397,783			$ 390,953	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 3,774,908	$ 4,397,783			$ 390,953	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 49,607	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 52,608	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,001	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 60,773	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 63,774	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	46,251	8
	1997	49,158	9
	1998	52,251	10
	1999	48,634	11
	2000	52,608	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FLORA PAVILION NURSING HOME CTR COUNTY CLAY

FACILITY IDPH LICENSE NUMBER 0038760

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-25-200-005		$ 55,248.32	$ 55,248.32
2.	"	Refund of incorrect Clay County Billi	$ (2,640.00)	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,608.32	$ 55,248.32

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 165,000	1
2					2
3	TOTALS			$ 165,000	3

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110		2000		$ 2,970,000	$ 108,000	27.5	$ 108,000	$	$ 184,507	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FANS			1993	1,891	48	39	48		410	9
10	ROOF			1993	15,000	385	39	385		3,257	10
11	DRIVEWAY			1993	16,855	432	39	432		3,546	11
12	STRIP PARKING LOT			1993	280	7	39	7		55	12
13	AWNING			1993	948	24	39	24		196	13
14	FROOF			1994	1,909	49	39	49		353	14
15	FRONT ENTRY REPAIR			1996	4,236	109	39	109		631	15
16	DUCT MODIFICATION			1996	11,970	307	39	307		1,650	16
17	CONCRETE WORK			1996	5,510	368	15	368		2,023	17
18	CONSULT REROOFING			1997	540	14	39	14		65	18
19	DOOR ALARM SYSTEM			1997	700	18	39	18		76	19
20	REPLACE ROOF			1997	14,760	378	39	378		1,528	20
21	ROOF TOP AC			1998	10,372	266	39	266		898	21
22	ROLLLING DOOR			1998	2,962	76	39	76		244	22
23	CARPET			1998	3,160	81	39	81		260	23
24	ROOF REPAIR			1999	16,688	429	39	429		1,269	24
25	PAINTING/FLOORING			1999	19,553	501	39	501		1,446	25
26	SEWER LINE/PUMP/SOIL TESTING			1999	3,537	91	39	91		224	26
27	HOT WATER HEATER			2000	4,579	1,121	20	228	(893)	342	27
28	ROOF REPAIR			2000	21,518	782	27.5	782		938	28
29	WASH/PAINT BUILDING			2000	4,820	175	27.5	175		270	29
30	BATHROOM REMODEL			2000	10,925	397	27.5	397		414	30
31	AC RETURN			2000	1,000	36	27.5	36		50	31
32				2001	25,160	572	27.5	572		572	32
33				2001	3,062	60	27.5	60		60	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,171,935	$ 114,726		$ 113,833	$ (893)	$ 205,284	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 173,136	$ 22,529	$ 17,314	$ (5,215)	10 YRS	$ 70,018	71
72	Current Year Purchases	10,386	412	519	107	10 YRS	519	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	190,864	42,552	19,086	(23,466)			74
75	TOTALS	$ 374,386	$ 65,493	$ 36,919	$ (28,574)		$ 70,537	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,711,321	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 180,219	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 150,752	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (29,467)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 275,821	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,815 Description: SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		1997 DODGE VAN	$ 765.00	$ 9,182	17
18					18
19					19
20					20
21	TOTAL		$ 765.00	$ 9,182	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 61,369	$		$ 61,369	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,177			9,177	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			5,306			5,306	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RESP. THERAIST					3,811			3,811	13
14	TOTAL			$		$ 79,663	$		$ 79,663	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 47,500)	476,064		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,135		6
7	Other Prepaid Expenses	165		7
8	Accounts Receivable (owners or related parties)	16,467		8
9	Other(specify): R/E ESCROW	13,776		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 564,607	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	201,935		15
16	Equipment, at Historical Cost	183,522		16
17	Accumulated Depreciation (book methods)	(148,374)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 237,083	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 801,690	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 531,047	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,000		28
29	Short-Term Notes Payable	329,994		29
30	Accrued Salaries Payable	52,976		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,053		31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,773		32
33	Accrued Interest Payable	6,409		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 986,252	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	479,969		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO LLC	599,707		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,079,676	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,065,928	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,264,238)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 801,690	$ 0	48

***(See instructions.)**

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,449,438)	1
2	Restatements (describe):		2
3	**W/O DUE TO/FROM MEDICARE**	48,956	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,400,482)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	136,244	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 136,244	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,264,238)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,990,982	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,990,982	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,817	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 63,817	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 0	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	4,076	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,076	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,058,875	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	526,485	31
32	Health Care	1,055,272	32
33	General Administration	592,548	33
	B. Capital Expense		
34	Ownership	608,438	34
	C. Ancillary Expense		
35	Special Cost Centers	79,663	35
36	Provider Participation Fee	60,225	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,922,631	40
41	**Income before Income Taxes (line 30 minus line 40)****	136,244	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 136,244	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,000	$ 36,881	$ 18.44	1
2	Assistant Director of Nursing	540	560	8,866	15.83	2
3	Registered Nurses	7,861	8,085	118,193	14.62	3
4	Licensed Practical Nurses	12,401	12,811	162,564	12.69	4
5	Nurse Aides & Orderlies	56,736	58,482	446,196	7.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,409	3,677	39,476	10.74	8
9	Activity Director	2,500	2,911	31,196	10.72	9
10	Activity Assistants	2,578	2,738	23,707	8.66	10
11	Social Service Workers	2,016	2,136	21,191	9.92	11
12	Dietician					12
13	Food Service Supervisor	1,300	1,360	17,351	12.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,082	7,184	48,921	6.81	15
16	Dishwashers	6,514	6,733	43,728	6.49	16
17	Maintenance Workers	2,029	2,181	39,264	18.00	17
18	Housekeepers	9,858	10,127	70,099	6.92	18
19	Laundry	4,988	5,159	31,533	6.11	19
20	Administrator	1,976	2,080	48,094	23.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,286	2,445	25,073	10.25	23
24	Clerical	1,984	2,064	17,134	8.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,742	1,774	15,701	8.85	31
32	Other Health Care(specify)	2,032	2,080	34,477	16.58	32
33	Other(specify) CARE PLAN COORD					33
34	TOTAL (lines 1 - 33)	131,832	136,587	$ 1,279,645 *	$ 9.37	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 2,316	1-3	35
36	Medical Director		6,500	9-3	36
37	Medical Records Consultant		1,701	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		450	10-3	39
40	Physical Therapy Consultant		840	10a-3	40
41	Occupational Therapy Consultant		575	10a-3	41
42	Respiratory Therapy Consultant		344	10a-3	42
43	Speech Therapy Consultant		1,300	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,026		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CATHY OESTREICH	ADMIN		$ 48,094
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 48,094

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 17,750
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 17,750

C. Professional Services

Vendor/Payee	Type	Amount
COBLE&MALONE	LEGAL	$ 1,237
MICHAEL BEST	LEGAL	468
WINSTON &STRAWN	LEGAL	1,215
ECONOCARE	ADMIN CONSULT	1,650
PERSONNEL PLANNERS	HR CONSULT	1,290
CERTIFIED HEALTH	ADMIN CONSULT	14,926
R.PEELO& ASSOC.	ACCTG SVCS	3,750
KRUPNICK,BOKOR,KAGDA	ACCTG SVCS	12,200
MILLINEUM/PAYMASTER	DATA PROCESSING	4,540
RELATED PARTY		7,370
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 48,646

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,595
Unemployment Compensation Insurance	28,494
FICA Taxes	97,986
Employee Health Insurance	67,827
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	0
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	245
INSURANCE - EXECUTIVE LIFE	0
RELATED PARTY	21,337
	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 242,484

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,442
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	15,576
TRUST FEES/FRANCHISE TX/ETC	0
CONTRIBUTIONS	0
DUES & SUBSCRIPTIONS	7,335
LICENSES & PERMITS	1,837
RELATED PARTY	309
Less: Public Relations Expense	(0)
Non-allowable advertising	(15,021)
Yellow page advertising	(555)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,923

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	110
Seminar Expense	
	1,386
RELATED PARTY	7,031
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,527

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1996	$ 23,850	3	$ 4,770	$ 4,770	$ 4,770	$ 2,385	$	$	$	$	$
2	PAINT/DECORATING	1997	1,608	3	536	536	268						
3	PAINT/DECORATING	1998	8,246	3	1,374	2,749	2,749	1,374					
4	PAINT/DECORATING	1999	3,051	3		508	1,017	1,017	509				
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 36,755		$ 6,680	$ 8,563	$ 8,804	$ 4,776	$ 509	$	$	$	$

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTHCARE ASSOC $6,400

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? NO

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 353 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 60,225
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: FLORA PAVILION NURSING HOME CTR #0038760 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	2,316	
	REPAIRS & MAINTENANCE		175	
				2,491
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		15,392	
	ELECTRICITY		40,371	
	WATER		9,838	
	CABLE TV - LOBBY		0	
			0	65,601
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,264	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,300	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		976	
	FIRE SERVICE		561	
				14,101
7	**OTHER**			
	SCAVENGER		9,382	
	SECURITY SERVICE		0	9,382
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,500	6,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		2,640	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,701	
	PHARMACY CONSULTANT	XVIII B 39-2	450	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
			0	
	NURSE PROGRAM CONSULT.		3,188	
	RN CONSULTANT	XVIII B 38-2		
			0	7,979
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	840	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	575	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	344	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	1,300	3,059
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOM			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
	ACTIVITY PROGRAM EXP		2,614	2,614
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR #0038760 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	17,750	17,750
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	4,540	
	ADMINISTRATIVE CONSULTANTS	XIX C	14,926	
	PROFESSIONAL FEES	XIX C	21,810	
			0	41,276
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	15,021	
	EMPLOYEE WANT ADS	XIX F	6,442	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	7,335	
	LICENSES & PERMITS	XIX F	1,837	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	555	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	31,190
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		1,186	
	EQUIPMENT REPAIR & MAINTENANCE		154	
	OUTSIDE CLERICAL SERVICES		99,960	
	PENALTIES / OVERDRAFT CHARGES	VI 18	375	
	HOME OFFICE EXPENSES		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		10,124	
	POSTAGE		4,133	
	MESSENGER SERVICE		0	
	STORAGE RENTAL		949	116,881

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	97,986	
	UNEMPLOYMENT COMPENSATION	XIX D	28,494	
	WORKERS COMPENSATION INSURANC	XIX D	26,595	
	HOSPITALIZATION INSURANCE	XIX D	67,827	
	EMPLOYEE BENEFITS - OTHER	XIX D	0	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	OTHER	XIX D	245	221,147
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,386	
	TRAVEL	XIX G	110	
			0	
			0	1,496
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,050	5,050
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		52,078	52,078
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 598,595

FLORA PAVILION NURSING HOME CTR
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	129,142
LESS SALES TAX	(543)
NET FOOD	129685
TOTAL PATIENT CENSUS	27,987
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	83961
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	83961
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	83961
NET FOOD	129685
DIVIDE TOTAL MEALS/YEAR	83961
COST PER MEAL	1.54
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	0

FLORA PAVILION NURSING HOME CTR
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2001

INCOME PER F/S									2,975,136	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	1,055,272	221,147	235,889	39,641	250,955	371,401	60,225	608,438		1,279,645
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	0		0			0		0		
CABLE TV			0			0				
CONTRACT NURSING										0
INTEREST INCOME							0			
NET VENDING COMMISSIONS										
EMPLOYEE PHYSICAL EXAMS		0				0				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(17,750)		17,750		
RESIDENT TAX REBILLED - PVT										
BAD DEBTS						0	0			
DISCOUNTS LOST							0			
AMORT-COMP SOFTWARE								0		
SETTLEMENT INTEREST										
RECLASSED SALARIES	0	0	0	0	0	0	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	0	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	1,055,272	221,147	235,889	39,641	250,955	353,651	60,225	626,188	2,842,968	1,279,645
PER FINANCIAL STATEMENTS	0	0	0	0	0	0	0	0	132,168	0
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									0	

FLORA PAVILION NURSING HOME CTR - COMPARISONS - 12/31/2001

	ref.	12/31/2001			12/31/2000			DIFF	12/31/1999		
CAPACITY DAYS		40,150			0			40,150	0		
CENSUS DAYS		27,987			0			27,987	0		
OCCUPANCY %		69.71%			#DIV/0!				#DIV/0!		
SALARIES											
TOTAL General Services	8-1	250,896	8.42%	8.96				250,896			
Social Services	12-1	21,191	0.71%	0.76				21,191			
TOTAL Health Care and Programs	16-1	938,448	31.51%	33.53				938,448			
Clerical & General Office Expenses	21-1	42,207	1.42%	1.51				42,207			
TOTAL General Administration	28-1	90,301	3.03%	3.23				90,301			
TOTAL Operation Expense	29-1	########	42.97%	45.72				########			
ADJUSTED TOTALS											
Food	2-8	124,523	4.18%	4.45				124,523			
Heat and Other Utilities	5-8	66,085	2.22%	2.36				66,085			
Maintenance	6-8	86,063	2.89%	3.08				86,063			
TOTAL General Services	8-8	527,923	17.73%	18.86				527,923			
Administrative	17-8	81,738	2.74%	2.92				81,738			
Directors Fees	18-8	0	0.00%	0.00				0			
Professional Services	19-8	48,646	1.63%	1.74				48,646			
Fees, Subscriptions, Promotions	20-8	15,923	0.53%	0.57				15,923			
License Fee-IDPA	Pg21	0	0.00%	0.00				0			
License Fee-Other	Pg21	1,837	0.06%	0.07				1,837			
Clerical & General Office Expenses	21-8	153,659	5.16%	5.49				153,659			
Employee Benefits & Payroll Taxes	22-8	242,484	8.14%	8.66				242,484			
Payroll Taxes	Pg21	126,480	4.25%	4.52				126,480			
W/C Insurance	Pg21	26,595	0.89%	0.95				26,595			
Health Insurance	Pg21	67,827	2.28%	2.42				67,827			
Inservice Training & Education	23-8	0	0.00%	0.00				0			
Travel and Seminar	24-8	8,527	0.29%	0.30				8,527			
Other Admin. Staff Transportation	25-8	13,739	0.46%	0.49				13,739			
Insurance-Prop.Liab.Malpractice	26-8	55,435	1.86%	1.98				55,435			
Other (specify):*	27-8	0	0.00%	0.00				0			
TOTAL General Administration	28-8	620,151	20.82%	22.16				620,151			
TOTAL Operation Expense	29-8	########	71.80%	76.41				########			
Real Estate Taxes	33-3	63,774	2.14%	2.28				63,774			
Real Estate Legal	Pg10	0	0.00%	0.00				0			
GRAND TOTAL COST	45-8	########	100.00%	**106.42**				########			
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		970244.5	32.58%	**34.67**	#DIV/0!	#DIV/0!	**#DIV/0!**	#DIV/0!	#DIV/0!	#DIV/0!	**#DIV/0!**

FLORA PAVILION NURSING HOME CTR - DIAGNOSTICS - 12/31/2001

This report reflects a 365-day year.

Page 3 Column 3 - Other is completely scheduled.

Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.

Total Adj on Page 4 Line 45-7 = Page 5 Line 37.

Deferred maint. adj. on Page 5A Line 1 consists of 4776 from Page 22 and 0 from Page 3 Line 6-3.

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.

Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-352635

Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.

Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.

Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-150552

Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.

Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.

Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.

Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.

Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.

Page 17 Assets = Liabilities & Capital.

Net income on Page 18 Line 7-1 = Page 19 Line 43-2.

Administrative Salaries on Page 3 Line 17-1 = Page 21-A.

Management fees on Page 3 Line 17-3 = Page 21-B.

Professional fees on Page 3 Line 19-3 DOES NOT EQUAL Page 21-C.

Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.

Dues, etc. on Page 3 Line 20-8 = Page 21-F.

Travel expenses on Page 3 Line 24-8 = Page 21-G.